



## AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION UPDATE

July 24, 2012

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

### Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

### Grant and Demonstration Announcements

**State Innovation Models: Funding for Model Design and Model Testing Assistance, §3021.** Announced July 19, 2012. Up to \$275 million in funding is available to state governments to design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance. Through the State Innovation Models initiative, states will work with a broad coalition of stakeholders (including employers, insurers, providers, consumers, and community-based organizations) to design or test innovative payment and service delivery improvements to health care systems for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries while eliminating unnecessary spending and maintaining or improving quality of care for program beneficiaries. The initiative provides two different funding opportunities; a state can apply for a Model Design award or a Model Testing award, but not both. Model design awards will provide financial and technical support in order to engage stakeholders and create a State Health Care Innovation Plan. Model testing awards will fund the implementation, testing and evaluation of the State Health Care Innovation Plan. Up to 25 states will receive Model Design cooperative agreements. The range for Model Design cooperative agreement awards is \$1 million to \$3 million. Applications are due September 17, 2012.

View the funding announcement at: [Grants.gov](http://www.grants.gov)

Learn more about the State Innovation Models initiative at:

<http://innovations.cms.gov/initiatives/state-innovations/index.html>

Read the press release at:

<http://www.hhs.gov/news/press/2012pres/07/20120719a.html>

## Guidance

### **7/24/12 IRS/Treasury published a correcting amendment to regulations**

**"Disregarded Entities and the Indoor Tanning Services Excise Tax."** The regulations, published in the Federal Register on June 25, 2012, affect disregarded entities responsible for collecting the indoor tanning services excise tax and owners of those disregarded entities. Effective July 1, 2010, ACA §10907 imposed a 10% excise tax on indoor tanning services. In general, providers of indoor tanning services collect the tax from consumers at the time the tanning services are purchased and the provider then pays over these amounts to the government. The tax does not apply to phototherapy services performed by a licensed medical professional on his or her premises. There is also an exception for certain physical fitness facilities that offer tanning as an incidental service to members without a separately identifiable fee. The June 2012 regulations amend the Internal Revenue Code and affect returns of this tax that are due on or after October 31, 2012.

According to the IRS/Treasury, the June 25, 2012 regulations contain possible misleading errors that are in need of clarification.

Read the correcting amendment at:

<http://www.gpo.gov/fdsys/pkg/FR-2012-07-24/pdf/2012-17959.pdf>

Read the June 25, 2012 final and proposed regulations at: <http://www.gpo.gov/fdsys/pkg/FR-2012-06-25/pdf/2012-15422.pdf>

Comments on these regulations or requests for a public hearing are due September 24, 2012.

For more information on the excise tax, read the IRS Frequently Asked Questions at:

<http://www.irs.gov/businesses/small/article/0,,id=224600,00.html>

### **7/20/12 The Office of Personnel Management (OPM) published a proposed rule "Federal Employees Health Benefits Program and Federal Employees Dental and Vision Insurance Program: Expanding Coverage of Children Federal Flexible Benefits Plan: Pre-Tax Payment of Health Benefits Premiums."**

The rule amends the Federal Employees Health Benefits Program (FEHB) regulations regarding coverage for children up to age 26 and for children of the same-sex domestic partners of FEHB enrollees. The regulations also allow children of same sex domestic partners to be covered family members under the Federal Employees Dental and Vision Insurance Program (FEDVIP).

Included in the changes, the proposed rule is intended to (1) Bring FEHB rules into compliance with changes to health insurance coverage for children under the ACA; (2) extend FEHB and FEDVIP benefits to children of same-sex domestic partners of Federal employees consistent with Executive action; and (3) to implement ACA-required changes to the Federal Benefits Plan: Pre-Tax Payment of Health Benefits Premiums in connection with the extension of FEHB coverage to children of same-sex domestic partners of Federal employees.

ACA §2714 requires group health plans and health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children to "continue to make such coverage available for an adult child until the child turns 26 years of age."

Read the regulation at: [Regulation](#)

Pursuant to the ACA, OPM issued guidance to FEHB carriers in [Carrier Letter No. 2010-18](#) and to agency benefit officers in [Benefits Administration Letter No. 10-201](#). In these guidance documents, OPM explained that the ACA and its implementing regulations allow married children to be covered; remove dependency requirements; remove residency requirements;

and do not require a child to be a student or to have prior or current insurance coverage in order to be placed on their parent's enrollment under the FEHB Program. This proposed rule updates FEHB regulations to align with current program policy by extending coverage to children up to 26 years of age, regardless of their marital status, dependency, residency, student status, or lack of insurance coverage with limited exceptions permitted under guidance issued under the Affordable Care Act.

Comments are due September 18, 2012.

Read the proposed rule at: <http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17537.pdf>

**7/18/12 HHS issued a final rule "Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans."** The final rule establishes data collection standards necessary to implement portions of §1302 of the ACA, which directs the HHS Secretary to define essential health benefits (EHB). The final rule outlines the data on applicable plans to be collected from certain issuers to support the definition of essential health benefits and also establishes a process for the recognition of accrediting entities for purposes of certification of qualified health plans (QHPs). The final rule includes data reporting standards for health plans that represent potential state-specific benchmark plans. Specifically, the final rule establishes that issuers of the largest three small group market products in each state report information on covered benefits.

All plans sold in the exchanges and through the small/non-group market must offer a set of **essential health benefits** (§1302), a package of ten categories of medical services and treatments which includes ambulatory and emergency care, maternity care, prescription drugs and other comprehensive health care services in ten categories. HHS has previously issued some guidance on EHB. A bulletin on HHS' intended benchmark approach to defining EHB was published on December 16, 2011. Read the EHB bulletin at: [CCIIO](#) On February 17, 2012, HHS issued a list of FAQs to provide additional guidance on the agency's intended approach to defining EHB. The set of FAQs contains further information about the process of selecting and updating a benchmark, states' responsibility with respect to state-mandated benefits, and the application of benchmarks to plans that have enrollees in multiple states. Read the FAQ's at: <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf> On January 25, 2012, CCIIO released a document "Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State" which provides information about the kinds of benchmark plans that states could consider when formulating their EHB packages. Read the "Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State" document at: [CCIIO](#) HHS stated that the agency expects to "pursue comprehensive rulemaking on essential health benefits in the future."

In addition, this rule establishes the first phase of a two-phased approach for recognizing accrediting entities to implement the standards established under the ACA for **qualified health plans** (QHPs) to be accredited on the basis of local performance by an accrediting entity recognized by the HHS Secretary on a timeline established by the Exchange and addresses some data sharing and performance requirements of the recognized accrediting entities. In the first phase, the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) would be recognized as accrediting entities on an interim basis. According to HHS, a criteria-based review process in phase two would be adopted through future rulemaking.

ACA §1311 provides that, in order to be certified as a QHP and operate in the Affordable Insurance Exchanges that will be operational in 2014, a health plan must be accredited. In a separate rule titled "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers" (Exchange Rule) published in

the March 27, 2012 Federal Register, HHS specified that a QHP issuer must be accredited by an entity recognized by HHS. Read the Exchange Rule at: <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>

Read the proposed Data Collection rule (which was published in the Federal Register on June 5, 2012) at: <http://www.gpo.gov/fdsys/pkg/FR-2012-06-05/pdf/2012-13489.pdf>

Read the final Data Collection rule (which was published in the Federal Register on July 20, 2012) at:

<http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf>

**7/17/12 CCIIO issued sub-regulatory technical guidance regarding the Medical Loss Ratio (MLR) regulation under §10101 of the ACA.** The bulletin, "CCIIO Technical Guidance (CCIIO 2012-0005): Questions and Answers Regarding the Medical Loss Ratio Reporting and Rebate Requirements," explains that the MLR provision requires health insurance issuers to submit an MLR report to the HHS Secretary and requires them to issue a rebate to enrollees if the issuer's MLR is less than the allowable MLR standard established under the ACA. The MLR rules establish the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care, not on income, overhead or marketing. Beginning in 2011, the ACA requires insurance companies in the individual and small group markets to spend at least 80% of collected premium dollars on medical care and quality improvement activities; insurance companies in the large group market are required to spend at least 85%. Insurance companies that do not meet the MLR standard are required to provide a notice about their MLR as well as rebates to their consumers, making the first round of rebates this summer of 2012.

In a question and answer format, the Bulletin provides MLR guidance on the following topics: Notice of Rebate, Notice of MLR Information, and Definition of Plan Document.

Read the final MLR rule at: <http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11753.pdf>

Read the bulletin at:

<http://cciio.cms.gov/resources/files/mlr-notice-of-rebate-faq-07172012.pdf>

Prior guidance can be viewed at: [www.healthcare.gov](http://www.healthcare.gov)

## **News**

**7/23/12 The GAO (Government Accountability Office) released a report "Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance."** According to the study, approximately 75% of the 7 million children who were uninsured in January 2009 would be eligible under the ACA for Medicaid, the State Children's Health Insurance Program (CHIP), or the new premium tax credit, leaving an estimated 1.7 million children uncovered.

The ACA expands Medicaid eligibility to everyone up to 133% FPL (\$2001) and provides subsidies and federal tax credits to buy private insurance to people with incomes between 100% FPL and 400% FPL (\$1401). According to the GAO report, the uninsured children expected to continue lacking coverage had family incomes too high to be eligible, were noncitizens, or would be ineligible for the premium tax credit because they would be considered to have access to affordable employer-sponsored insurance under the IRS' proposed affordability standard. Under the [IRS Health Insurance Premium Tax Credit final regulations](#), the IRS based the ACA definition of affordability for an employee's eligible family members on the cost of an employee-only plan. In the regulations the IRS finalized its rule but deferred finalizing the proposed affordability standard.

The report also underscores that the accuracy of its estimates is highly dependent on future rulemaking actions at the IRS, whether or not states choose to expand their Medicaid programs under the ACA and whether or not CHIP is funded beyond 2015. The GAO study includes a recommendation that the IRS should reconsider applying the affordability test to individual coverage only.

Read the GAO report at: <http://www.gao.gov/assets/600/591797.pdf>

**7/23/12 The Patient-Centered Outcomes Research Institute, known as PCORI, announced it is accepting comments on its draft Methodology Report**, which proposes standards for the conduct of patient-centered outcomes research. The report explores best practices for comparative effectiveness research and is intended to guide researchers as they formulate questions and determine the best methods to use in producing a PCORI-funded study.

Created under §6301 of the ACA, PCORI is an independent nonprofit, expected to provide billions in federal funds for studies, and tasked with conducting patient-centered outcomes research.

PCORI is accepting comments on the draft report through [an online comment and survey tool](#) where respondents may answer a series of general and specific questions about the report. A PCORI committee will review the comments and revise the draft for finalization by PCORI's Board of Governors in November, 2012. The report will also be revised as new research methods are implemented and verified, to ensure it remains the basis for reliable patient-centered outcomes research.

In May PCORI issued its first funding announcement. PCORI Funding Announcements are issued to support comparative clinical effectiveness research that will provide patients with the ability to make better-informed health care decisions and that is based on PCORI's [National Priorities for Research and Research Agenda](#).

For more on funding announcements, visit:  
<http://www.pcori.org/funding-opportunities/funding-announcements/>

According to PCORI, adherence to the standards in the finalized Methodology Report will be required in future funding cycles.

Comments are due September 14, 2012.

Read the draft Methodology Report at:  
<http://pcori.org/assets/MethodologyReport-Comment.pdf>

**7/18/12 CMS announced that out of the 89 new organizations that it announced last month as participating in the Medicare Shared Savings Program on July 1, 2012, 15 of those accountable care organizations (ACOs) will also be participating in the Advanced Payment Model.**

The Medicare Shared Savings Program, a program authorized by §3022 of the ACA, helps to facilitate coordination among providers to improve the quality of care for Medicare beneficiaries. Specifically, the Advance Payment ACO Model allows smaller physician practices and rural providers to receive some start-up funding that to make important investments in their care coordination infrastructure that would later be recouped out of the entries sharing

savings.

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve to help ensure that patients, especially the chronically ill, get appropriate care, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. Medicare offers several ACO programs, including: 1) Medicare Shared Savings Program (for fee-for-service beneficiaries), 2) Advance Payment Model (for certain eligible providers already in or interested in the Medicare Shared Savings Program) and 3) Pioneer ACO Model (Health care organizations and providers already experienced in coordinating care for patients across care settings).

Arbor Medical Associates PC from South Weymouth, Massachusetts is included in the list of new Advanced Payment Model participants. Read more about the ACOs announced at:

<http://innovations.cms.gov/initiatives/ACO/Advance-Payment/index.html>

In April CMS announced 5 Advance Payment ACOs; the additional 15 announced brings the total number of Advance Payment ACOs to 20. The additional Advance Payment ACOs announced bring the total number of organizations participating in Medicare Shared Savings initiatives to 154, including the 32 ACOs participating in the testing of the Pioneer ACO Model by CMS's Center for Medicare and Medicaid Innovation (Innovation Center) announced in December 2011, and six Physician Group Practice Transition Demonstration organizations that started in January 2011. In all, as of July 1, more than 2.4 million beneficiaries are receiving care from providers participating in Medicare Shared Savings initiatives.

Learn more about the Pioneer Model at: [Innovations](#)

Learn more about the Physician Group Practice Transition Demonstration at: [CMS](#)

According to CMS, the agency will allow organizations who are applying to participate in the Medicare Shared Savings Program beginning January 1, 2012, to apply to participate in the Advance Payment ACO Model. Interested organizations must apply to both the Medicare Shared Savings Program and the Advance Payment ACO Model to gain consideration.

More information, including application requirements, is available at: [Information](#)

## EOHHS News

### **Request for Responses from Integrated Care Organizations**

On June 19, the Executive Office of Health and Human Services (EOHHS) issued a Request for Responses (RFR) to solicit proposals from Integrated Care Organizations (ICOs) to participate in the Duals Demonstration program. The purpose of this Demonstration is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for dual eligibles. Under this program the selected ICOs will be accountable for the delivery and management of all covered medical, behavioral health, and long-term services and supports for their enrollees. The RFR and related appendices are posted at:

[www.mass.gov/masshealth/duals](http://www.mass.gov/masshealth/duals) and on the state procurement website Comm-PASS ([www.comm-pass.com](http://www.comm-pass.com)) under the Document Number 12CBEHSDUALSICORFR.

**Responses to the RFR will be due to EOHHS by 4:00 PM (EDT), July 30, 2012.**

Read more at: [RFR](#)

## Upcoming Events

**Money Follows the Person Stakeholder Meeting**

August 15, 2012, 2:00 PM - 3:30 PM

Worcester Senior Center

128 Providence Street

Worcester, MA 01545

Free parking is available at the Worcester Senior Center parking lot located behind the Center and is accessible from Spurr Street. Handicapped parking is available in this lot as well as along the front entrance driveway off of Providence Street. Please contact [MFP@state.ma.us](mailto:MFP@state.ma.us) RSVP and to request reasonable accommodations. Although RSVPs are greatly appreciated, they are not required.

An **MFP 101 introductory session** will also be at the Worcester Senior Center and will begin at 1:30 p.m. on August 15, 2012.

**Integrating Medicare and Medicaid for Dual Eligible Individuals Open Meeting**

July 27, 2012, 10:00 AM - 12:00 PM

State Transportation Building, Conference Rooms 1, 2, & 3, Second Floor, 10 Park Plaza  
Boston, MA

The purpose of this meeting will be to give an update on the Demonstration, and to focus on consumer issues.

Reasonable accommodations will be made for participants who need assistance. Please send your request for accommodations to Donna Kymalainen at [Donna.Kymalainen@state.ma.us](mailto:Donna.Kymalainen@state.ma.us)

Bookmark the **Massachusetts National Health Care Reform website**

at: [http://mass.gov/national\\_health\\_reform](http://mass.gov/national_health_reform) to read updates on ACA implementation in Massachusetts.

Remember to check <http://mass.gov/masshealth/duals> for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.